

NORTH
CAROLINA

child
ADVOCACY
Institute

health policy
North Carolina Institute of Medicine

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Child Health Report Card



IN COLLABORATION WITH:

Women's and Children's Health Section,
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The purpose of the North Carolina Child Health Report Card is to heighten awareness of the health of our children by summarizing in one brief document data on important child health indicators. This eighth annual Report Card is produced to assist health administrators, legislators, and family advocates in their efforts to improve the health and safety of children statewide.

Statewide data are presented for the most current year available and a comparative year (usually 1996) as a benchmark. Unless otherwise noted, data are presented for calendar years. The specific indicators were chosen not only because they are important, but also because there are data available. In time, we hope expanded data systems will begin to produce accurate data that would allow the "picture" of child health and safety to expand as well. For several indicators, county data can be accessed through the web site of the NC Child Advocacy Institute (www.ncchild.org).

The data provide reason for celebration and concern. There is plenty to celebrate. For most indicators, the trend is toward improvement, and for several—including infant and child death rates; uninsured rates; the immunization rate; teen pregnancy—the data are truly encouraging. However, there is also cause for heightened concern and strong action. For several indicators—including child abuse and neglect; child abuse homicide; asthma; overweight in low-income children; the use of alcohol, tobacco, and illegal substances—the data reflect unnecessary and unacceptable risks to NC children and youth. When data are available, they indicate that racial disparities remain disturbingly wide.

As noted in prior Report Cards, North Carolina's child health outcomes are not a matter of happenstance, nor are they inevitable. Our results—good, bad, or indifferent—invariably mirror investments made by the General Assembly and the hard work and perseverance of coalitions that include state and local agencies, providers, and child/family advocates. Regrettably, the current state budget crisis is placing much of this progress in jeopardy, with some critical health services being reduced and most remaining seriously underfunded.

While the frequently-stated goal of being "First in America" in the formal education of our children is laudable, there is no way to achieve that goal if our children are nowhere near first in measures of health and safety. Attention to the relationship between student health/well-being and student success in school is a challenge for all North Carolinians. Our children are 20% of our population, but they are 100% of our future. They will soon be our leaders, our producers, and our consumers. Now is the time to make the investments that will assure a bright future for our state.

Grades and Trends

Grades are assigned to bring attention to the current status of each indicator, and are based on a general consensus among the sponsoring organizations. A indicates that the current status is "very good"; B is "satisfactory"; C is "mediocre"; D is "unsatisfactory"; F is "very poor".

Trends are represented by arrows: ↑ indicates the data are improving; ↓ indicates the data are becoming worse; → indicates no change from the reference year. Regardless of the grade, the trend reminds us if progress is being made, and progress should be our goal in every case.

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| Health Indicator | Current Year | Benchmark Year | Δ | Grade & Trend | |
|--|--------------|----------------|---------|---------------|---|
| Insurance coverage¹ | 2001 | 1997 | | | |
| Health Choice enrollment (age 0-18) | 65,467 | 0 | N/A | A | ↑ |
| Medicaid enrollment (age 0-18) | 568,668 | 491,286 | + 16% | B | ↑ |
| | 2000 | 1997 | | | |
| % of all children (age 0-18) in target group uninsured | 13.3 | 15.7 | - 15.3% | B | ↑ |
| % of all children (age 0-18) uninsured | 10.4 | 11.8 | - 11.9% | B | ↑ |
| Medicaid Preventive Care² | 2000 | 1996 | | | |
| % of Medicaid-enrolled children (age 0-18) receiving preventive care | 71.5 | 47.8 | + 50% | A | ↑ |
| Infant Mortality³ | 2001 | 1996 | | | |
| # of infant deaths per 1000 live births: | | | | | |
| All | 8.5 | 9.2 | - 8% | B | ↑ |
| White | 6.1 | 7.1 | - 14% | B | ↑ |
| Other races | 14.8 | 14.3 | + 3% | D | ↓ |
| Low Birth-Weight Infants⁴ | 2001 | 1996 | | | |
| % of infants born weighing 5 lbs., 8 ozs. or less: | | | | | |
| All | 9.0 | 8.7 | + 3% | D | → |
| White | 7.3 | 6.8 | + 7% | D | ↓ |
| Other races | 13.1 | 13.3 | - 2% | F | → |
| Immunization Rates⁵ | 2001 | 1996 | | | |
| % of children with appropriate immunizations: | | | | | |
| At age 2 | 87.5 | 78 | + 10% | A | ↑ |
| At school entry | 99.2 | 98 | + 1% | A | → |
| Communicable Diseases⁶ | 2001 | 1996 | | | |
| # of newly reported cases: | | | | | |
| Congenital Syphilis | 19 | 31 | - 39% | B | ↑ |
| Perinatal HIV/AIDS | 1 | 10 | - 90% | A | ↑ |
| Tuberculosis (age 0-19) | 12 | 13 | - 8% | C | → |
| Vaccine-Preventable Communicable Diseases⁷ | 2001 | 1996 | | | |
| # of reported cases (age 0-18): | | | | | |
| Measles | 0 | 2 | - 100% | A | ↑ |
| Mumps | 3 | 18 | - 83% | A | ↑ |
| Rubella | 0 | 9 | - 100% | A | ↑ |
| Diphtheria | 0 | 0 | 0% | A | → |
| Pertussis | 58 | 128 | - 55% | B | ↑ |
| Tetanus | 0 | 0 | 0% | A | → |
| Polio | 0 | 0 | 0% | A | → |

| Health Indicator | Current Year | Benchmark Year | Δ | Grade & Trend | |
|---|-------------------|-------------------|---------|---------------|---|
| Environmental Health⁸ | 2001 | 1996 | | | |
| Lead: % of children (age 12-36 months): | | | | | |
| Screened for elevated blood levels | 35 | 34.2 | + 2.3% | C | → |
| Found to have elevated blood lead levels | 1.8 | 5.8 | - 70% | B | ↑ |
| Asthma: % of children (grade 7-8) who have: | 2000 | 1995 | | | |
| Reported asthma symptoms | 28 | N/A | N/A | C | |
| Diagnosed asthma | 11 | N/A | N/A | C | |
| Asthma: Hospital discharges per 100,000 children (age 0-14): | 2001 | 1996 | | | |
| All | 207.2 | 239.8 | - 14% | C | ↑ |
| White | 92.7 | 132.0 | - 30% | B | ↑ |
| Other races | 250.0 | 377.7 | - 34% | C | ↑ |
| Dental Health⁹ | FY 2001 | FY 1996 | | | |
| % of children with one or more sealants (Grade 5) | 37 | 28 | + 32% | B | ↑ |
| % of population on fluoridated water systems | 89 | 89 | 0% | A | → |
| % of Medicaid-eligible children: | FY 2001 | 1998 | | | |
| Ages 1-5 who received dental services | 30.1 | 12 | + 151% | D | ↑ |
| Ages 6-14 who received dental services | 22.9 | 27 | - 15% | F | ↓ |
| Ages 15-20 who received dental services | 17.4 | 19 | - 8% | F | ↓ |
| Early Intervention¹⁰ | 2001 | 1996 | | | |
| # of children (age 0-3) enrolled in early intervention services to reduce effects of developmental delay, emotional disturbance, and/or chronic illness | 9,845 | 8,454 | + 16% | B | ↑ |
| Child Abuse & Neglect¹¹ | FY 00-01 | FY 96-97 | | | |
| # of children: | | | | | |
| Receiving assessments for abuse & neglect | 102,158 | 83,257 | + 23% | F | ↓ |
| Substantiated as victims of abuse & neglect | 32,581 | 28,619 | + 14% | F | ↓ |
| Confirmed deaths due to abuse | 2001 24 | 1996 45 | - 47% | D | ↑ |
| Child Fatality¹² | 2001 | 1996 | | | |
| # of deaths per 100,000 children (age 0-17) | 76.4 | 90.7 | - 15.7% | B | ↑ |

| Health Indicator | Current Year | Benchmark Year | Δ | Grade & Trend |
|--|--------------|----------------|-------|---------------|
| Deaths Due to Injury¹³ | 2001 | 1996 | | |
| # of deaths (age 0-18): | | | | |
| Motor Vehicle-related | 171 | 182 | - 6% | C ↑ |
| Drowning | 25 | 35 | - 29% | C ↑ |
| Fire/Burn | 7 | 33 | - 79% | A ↑ |
| Bicycle | 8 | 18 | - 56% | A ↑ |
| Suicide | 29 | 37 | - 22% | D ↑ |
| Homicide | 43 | 69 | - 38% | F ↑ |
| Firearm | 36 | 68 | - 47% | F ↑ |
| Alcohol, Tobacco & Substance Abuse¹⁴ | 2001 | 1995 | | |
| % of students in grades 9-12 who reported using the following in the past 30 days: | | | | |
| Cigarettes | 27.8 | 31.1 | - 11% | D ↑ |
| Smokeless Tobacco | 8.9 | 9.2 | - 3% | C → |
| Marijuana | 20.8 | 21.7 | - 4% | F → |
| Alcohol (beer) | 38.2 | 39.7 | - 4% | F → |
| Cocaine | 2.7 | 2.2 | + 23% | F ↓ |
| Physical Activity¹⁴ | 2001 | 1995 | | |
| %(Grades 9-12) who exercised at least 20 minutes a day, at least 3 days in the past week | 64 | 61.3 | + 4% | C → |
| Overweight¹⁵ | 2001 | 1996 | | |
| % of low-income children who are overweight: | | | | |
| Age 2-4 | 12 | 9.4 | + 28% | D ↓ |
| Age 5-11 | 20.3 | 15.9 | + 28% | F ↓ |
| Age 12-18 | 26 | 24.4 | + 7% | D ↓ |
| Teen Pregnancy¹⁶ | 2001 | 1996 | | |
| # of pregnancies per 1,000 girls (age 15-17): | | | | |
| All | 40.6 | 65 | - 38% | C ↑ |
| White | 32.0 | 49 | - 35% | C ↑ |
| Other races | 59.5 | 101.3 | - 41% | C ↑ |

Notes:

1. Insurance Coverage. For many years, NC's Medicaid Program has been recognized as one of the better programs in the nation. NC Health Choice for Children, the state children's health insurance program implemented late in 1998, has been acclaimed in several national studies as one of the best such programs. A community-based outreach initiative led to large increases in NC Health Choice enrollment while also increasing Medicaid enrollment. However, too many children remain uninsured, particularly in the target group (those under 200% of the federal poverty guidelines) and more progress is needed in this area. It should be noted that NC Health Choice was frozen from January 1, 2001 to October 8, 2001 because enrollment and costs exceeded the state budget for the program. The General Assembly passed an appropriation to expand enrollment in 2001 and again in 2002 because of continued program growth. Data collected for both Medicaid and NC Health Choice are from September 2001.

2. Medicaid Preventive Care. The percentage of Medicaid-enrolled children receiving preventive care on a continuing basis increased by a remarkable 50% between 1996 and 2001. This significant increase can be attributed to the Carolina Access Program, which links enrolled children with primary care providers, and to the outreach efforts of the Health Check Initiative. The increase is even more remarkable because Medicaid enrollment increased significantly during this period due to expanded access provided by the General Assembly. Since more progress is needed in this area, it is critical that the Carolina Access Program and outreach efforts remain in place.

3. **Infant Mortality.** The 2001 infant mortality rate of 8.5 is the lowest ever recorded in NC, representing an 8% reduction since 1996 and a notable 22% reduction in the past decade. This reflects great progress in reducing deaths from birth defects and sudden infant death syndrome. Both areas have received financial investments by the General Assembly and have been the focus of services and awareness campaigns generated by the NC Department of Health and Human Services (DHHS) and community agencies. Regrettably, these investments are in jeopardy due to the state's budget crisis. The difference between whites and other races has been the focus of attention for some time, but the disparity in outcomes shows signs of widening, and is cause for concern.
4. **Low Birth-Weight Infants.** Low birth-weight is a serious component of infant mortality that has remained intractable over the years. Efforts to reduce this problem are now shifting to the preconception period. It has been noted that women with a history of positive health behaviors prior to pregnancy have better birth outcomes. School health curricula and general awareness campaigns can play a big role in this regard.
5. **Immunization Rates.** Federal reports indicate that North Carolina's 87.5% immunization rate at age two ranks among the best in the nation. This true success story is directly attributable to a decision by the General Assembly to make vaccines available to children at low or no cost, and to a statewide initiative that enjoys the participation of primary care providers.
6. **Communicable Diseases.** While still disappointingly high, the number of newly reported congenital syphilis cases has dropped dramatically in the past five years. Continuing progress is hoped for. Through a statewide system of providing voluntary counseling and drug intervention, the transmission of AIDS from mother to child during the birth process has become a rare event in NC, for which public and private providers should be proud. While the number of newly reported tuberculosis cases remains relatively low, it is disappointing that this disease still affects our children.
7. **Vaccine-Preventable Communicable Diseases.** These diseases are no longer the childhood afflictions they used to be, due to the development of vaccines, the expanded availability of vaccines, and a statewide surveillance system guided by the NC DHHS. Measles, tetanus, polio, and diphtheria have been virtually eliminated. Cases of mumps and pertussis have been markedly reduced. For the first time in several years, no cases of rubella were reported, which is a testimony to the work of local health departments in providing immunization education and services particularly focused on new immigrant populations.
8. **Environmental Health.** After a period of rapid growth, the percent of children ages 12-36 months screened for blood lead levels has changed very little in the past five years. Despite a statewide awareness initiative and the participation of private physicians and local health departments (and the WIC Programs in particular), only 35% of children were screened in 2001, a disappointingly low percentage given the adverse effects of elevated blood lead (defined as 10 micrograms per deciliter) on child development. Conversely, the percent of screened children who are found to have elevated blood lead levels has declined dramatically in the past five years, largely due to successful awareness campaigns and the continued reduction in exposure to products containing lead.

The NC School Asthma Survey was conducted in 1999-2000 on most seventh- and eighth-graders and produced for the first time relatively accurate estimates of asthma prevalence. The prevalence of diagnosed asthma of 11%, with an additional 17% with asthma-like symptoms, confirms that asthma is the leading chronic illness among our school-age children. There were few urban-rural and racial differences in prevalence. However, the wide racial disparity in discharge rates appears to indicate that minorities have less access to preventive and primary care services, necessitating their greater use of hospital care. The Asthma Alliance has been formed to aggressively address asthma from medical, educational, and environmental perspectives.
9. **Dental Health.** Data for preventive dental health, taken from surveys conducted by the NC DHHS Oral Health Section, show steady gains. Awareness efforts regarding the effectiveness of sealants (and now fluoride varnish for young children) continue to be enhanced. Access to dental services for the youngest Medicaid-enrolled children is rising, due to the provision of fluoride varnish by physicians. In general, access to dentists still remains very low, which is in part a reflection that dental reimbursement rates are too low.
10. **Early Intervention.** Program caseloads continue to increase, and NC's collaborative early intervention services system continues to receive national acclaim. Despite these impressive enrollment numbers, program administrators estimate that as little as 50% of the target population is being served. While efforts to expand and strengthen these services have been a priority of the Administration, the budget crisis has led the General Assembly to reduce appropriations in this area.
11. **Child Abuse and Neglect.** Though the number of children receiving assessments and the number of children substantiated as victims of abuse and neglect have moderated in the past few years, these numbers are rising and are still alarmingly high. Were it a communicable disease, child abuse and neglect would be declared an epidemic in NC. Tragically, the 24 confirmed deaths due to abuse represent more than half of child homicides, further confirming that home can be a dangerous place for far too many of our children.
12. **Child Fatality.** The rate of child deaths in 2001 is the lowest ever reported, representing a 15.7% decline since 1996 and a 29% decline in the past decade. Declines occurred in all age categories. The NC Child Fatality Task Force, as well as state and local review teams, continue to explore ways to prevent child deaths.
13. **Deaths Due to Injury.** This is the primary cause of death in children older than one year of age. For the first time, the number of deaths has declined in all categories, even though the total number of children in the population has increased significantly in the past five years. Progress in reducing motor vehicle-related deaths is attributed to the new graduated drivers' license requirements as well as increased enforcement of seat belt laws. A new bicycle helmet law should continue to help. Awareness campaigns and parental vigilance are needed to reduce unintentional injuries. Cases of homicide and suicide, though in decline, are a continuing tragedy.
14. **Alcohol, Tobacco, Substance Abuse, and Physical Activity.** These data, which indicate marginal improvement in most areas, are derived from the biennial Youth Risk Behavior Survey conducted by the Department of Public Instruction in cooperation with the Centers for Disease Control and Prevention. Though there are some questions regarding the validity of the survey process, these data indicate a need for continued efforts to reduce the risk-taking behaviors of our school children of all ages.
15. **Overweight.** This is conservatively defined as a body mass index equal to or greater than the 95th percentile using federal guidelines. Concern about overweight prevalence occurs when it exceeds 5%. The NC data for all age groups are well above that level of concern, and are getting worse. This does not bode well, for childhood obesity can lead to adult problems, such as high blood pressure, heart disease, diabetes, etc. While the children represented in these data are those who receive services in local health departments or school health centers and may not be representative of the state as a whole, the data are sending an important signal that must be heeded. The recommendations of the new NC Healthy Weight Initiative deserve consideration and support.
16. **Teen Pregnancies.** The national decline in teen pregnancies is being experienced in NC as well. While the data are quite encouraging, it is clear that more progress must be made in this area. Of particular concern is the wide disparity in the white and non-white rates. The non-white rate continues to be almost twice the white rate and thus remains an area of great concern.